Medical Care Program
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KAISER PERMANENTE

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David Werdegar, MD, M.P.H.
Office of Statewide Health Planning and Development
Office of the Director
1600 9th Street, Room 433
Sacramento, California 95814

Dear Dr. Werdegar:

The Kaiser Permanente Medical Care Program would once again like to thank the Office of Statewide Health Planning and Development (OSHPD) and its contractors in their effort to assess quality of care in California hospitals. We are pleased that these results continue to reflect the high-quality care provided at Kaiser Foundation Hospitals, especially at our San Diego hospital, but are concerned that methodological issues may be masking excellent performance at our other hospitals.

Our hospitals have extensive quality improvement and peer review programs in place, as well as a Regional Cardiac Services Committee to facilitate regionwide review and sharing of successful or innovative practices. All hospitals have in-house cardiologists readily available to hospital patients. We have regional guidelines in place for the prevention and treatment of AMI. Our efforts at monitoring our processes of care show that most AMI patients at our hospitals, eligible for thrombolytic or other pharmacologic therapy, appropriately receive such treatment.

In recent years, our hospitals have established or expanded programs for ensuring AMI patients receive the highest quality care. Examples of these strategies include: the use of preprinted orders for the administration of thrombolytics, beta-blockers, lipid-lowering medications, and aspirin; care paths; preprinted discharge orders for medications; case management programs; cholesterol clinics; and patient education. We expect that the results of these efforts will enhance the standing of Kaiser Foundation Hospitals in future reports.

In our review of the methodology used to obtain these results, we identified some issues on which we would like to elaborate. We share these issues with you in the hope that you will consider them when planning future reports of this nature.

First, the results are based on data that are over four years old and do not reflect current practices. For example, a case management program for patients with coronary artery disease has been developed in the past year at two of our hospitals. Second, the methodological change in the mortality measure from past reports prevents comparisons over time.

OSHPD spent considerable time and resources validating its previous measure of mortality, 30-day in-hospital mortality. In this current report the outcome measure has been changed to 30-day mortality, regardless of where the death occurred, a measure that has not been validated by OSHPD. We believe that 30-day mortality introduces too many unmeasured intervening variables that are beyond the control of the hospital (e.g., the likelihood that a patient who has been discharged and is experiencing adverse events will return to the hospital is influenced by the patient's level of education, support network, proximity to hospital care, transportation resources, etc.) It also raises the issue of patient compliance with the treatment protocol outside the hospital setting. Hospitals may not have the opportunity to provide additional care to patients who have been discharged.

However, we recognize that hospitals are responsible for ensuring that patients are discharged in a stable condition. The earlier measure, 30-day in-hospital mortality, may have rewarded hospitals for discharging patients too early. A compromise might be to measure 15-day mortality. Deaths that occur in this time frame, regardless of location, might better reflect care and processes available at hospitals and limit the influence of the intervening variables mentioned above. If further changes in the outcome measure are made it would be helpful to simultaneously report the past measure to allow for comparisons over time. Also, new outcome measures should be validated prior to the release of reports.

In closing, we would like to remind readers of this report to keep in mind the limitations we and others have raised. The Kaiser Permanente Medical Care Program is committed to quality improvement and looks forward to seeing the results of our efforts accurately and fairly reported in future reports.

Sincerely,

Edgar T. Carlson
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